1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Kineret® Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Moderately to severely active rheumatoid arthritis
- ❑ Neonatal-onset multisystem inflammatory disease (NOMID)
- ❑ Systemic juvenile idiopathic arthritis (SJIA)
- ❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical Information:

Select if Kineret will be used in combination with any of the following**:**

- ❑ Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
- ❑ Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- ❑ Not in combination with a biologic DMARD or janus kinase inhibitor

Select if Kineret is prescribed by or in consultation with one of the following specialists:

- ❑ Allergist/Immunologist ❑ Rheumatologist

For moderately to severely active rheumatoid arthritis, also answer the following:

Does the patient have history of failure, contraindication, or intolerance to one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., Rheumatrex/Trexall (methotrexate), Arava (leflunomide), Azulfidine (sulfasalazine)]? ❑ **Yes** ❑ **No**

Is this request for continuation of prior Kineret therapy? ❑ **Yes** ❑ **No**

Select if the patient has history of failure, contraindication, or intolerance to the following:

- ❑ Cimzia (certolizumab)
- ❑ Humira (adalimumab)
- ❑ Simponi (golimumab) or Simponi Aria (golimumab IV)

For neonatal-onset multisystem inflammatory disease (NOMID), also answer the following:

Select if the patient has a diagnosis of NOMID as confirmed by the following:

- ❑ NLRP-3 [nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3 gene (also known as cold-induced auto-inflammatory syndrome-1 [CIAS1]) mutation
- ❑ Evidence of active inflammation which includes clinical symptoms (e.g., rash, fever, arthralgia)
- ❑ Evidence of active inflammation which includes elevated acute phase reactants (e.g., ESR, CRP)

For systemic juvenile idiopathic arthritis (SJIA), also answer the following:

Does the patient have active SJIA? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to a non-steroidal anti-inflammatory drug (NSAID) [e.g., Motrin (ibuprofen), Naprosyn (naproxen)]? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to a systemic glucocorticoid (e.g., prednisone)? ❑ **Yes** ❑ **No**

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Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had a positive clinical response to Kineret therapy? ❑ **Yes** ❑ **No**

Select if Kineret will be used in combination with any of the following**:**

- ❑ Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
- ❑ Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- ❑ Not in combination with a biologic DMARD or janus kinase inhibitor

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	